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UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

CHRISTOPHER GARZA, Plaintiff, v. CITY OF SALEM, an Oregon municipal corporation; and OFFICER DAVID BAKER, an individual, Defendants.	Case No. 3:22-cv-00721-HZ **DEFENDANTS' FRCP 26(a)(2) EXPERT DISCLOSURES**

Pursuant to Federal Rules of Civil Procedures 26(a)(2) and the stipulated Supplemental Scheduling Order, Defendants City of Salem and Officer David Baker makes the following expert disclosures.

RETAINED EXPERTS

1. Dr. Tom Faciszewski, M.D., MBA is a Board Certified, Orthopaedic Surgeon.

FRCP 26(a)(2(B)(i). Dr. Faciszewski report of all opinions he will express and the basis and reasons for them are attached hereto as Exhibit 1.

FRCP 26(a)(2(B)(ii): The facts and data considered by Dr. Faciszewski in forming his opinions is set forth in his report attached as Exhibit 1, pages 2-3.

FRCP 26(a)(2(B)(iii): Exhibits that will be used to summarize or support Dr. Faciszewski's opinions are set forth in Exhibit 1 to Dr. Faciszewski's report.

FRCP 26(a)(2)(B)(iv): A copy of Dr. Faciszewski's CV, which describes his training, qualifications, and publications authored in the last 10 years is attached hereto as Exhibit 1, page 20.

FRCP 26(a)(2)(B)(v): Cases in which Dr. Faciszewski's has testified in the previous 4 years are set forth in Exhibit 1, page 33.

FRCP 26(a)(2)(B)(vi): Dr. Faciszewski's statement of compensation to be paid for the study and testimony is set forth in Exhibit 1, page 35.

2. Brian Harvey is an expert in police use of force.

FRCP 26(a)(2(B)(i). Mr. Harvey report of all opinions he will express and the basis and reasons for them are attached hereto as Exhibit 2.

FRCP 26(a)(2(B)(ii): The facts and data considered by Mr. Harvey in forming his opinions is set forth in his report attached as Exhibit 2, pages 2-3.

FRCP 26(a)(2(B)(iii): Exhibits that will be used to summarize or support Mr. Harvey's opinions are set forth in Exhibit 2 to Mr. Harvey's report.

FRCP 26(a)(2)(B)(iv): A copy of Mr. Harvey's CV, which describes his training, qualifications, and publications is attached hereto as Exhibit 2, page 8.

FRCP 26(a)(2)(B)(v): Cases in which Mr. Harvey's has testified in the previous 4 years are set forth in Exhibit 2, page 7.

FRCP 26(a)(2)(B)(vi): Mr. Harvey's statement of compensation to be paid for the study and testimony is set forth in Exhibit 2, page 7.

DATED: September 29, 2023.

s/ Sebastian Tapia
Sebastian Tapia, OSB No. 043761
Attorney for Defendants

UNITED STATES DISTRICT COURT

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FEDERAL RULES OF CIVIL PROCEDURE 26(a)(2)(B)
EXPERT REPORT

In compliance with FRCP 26(a)(2)(B), I hereby certify that this report is a complete and accurate statement of my opinions and the basis and reasons for them, to which I will testify under oath.

DATED: September 27, 2023

Tom Faciszewski, MD, MBA
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September 29, 2023

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Claimant:	**Christopher Garza**
Claim No.:	**3:22-cv-00721-HZ**
Date of Loss:	**September 17, 2021**

Dear Mr. Tapia:

Please review the enclosed **Independent Medical Record Review** report which was produced to document the review that was performed by Tom Faciszewski, MD, MBA, Board Certified Orthopaedic Surgeon.

Please review the following report:

RECORDS REVIEWED:

Garza 1 (St. Moscati) (GARZA 000015-41)
Garza 2 (Hope Orthopedics) (GARZA 000046-78)
Garza 3 (Willamette Surgery Center) (GARZA 000090-110)
Garza 4 (Salem Health) (GARZA 000118-398)
Garza 5 (St. Moscati priors) (GARZA 000418-420)
Garza 6 (Salem Health priors) (GARZA 000421-427, 000431-542, 000552- 572, 000579-873)
Garza 7 (Salem Pain and Spine) (GARZA 000912-934)
Garza 8 (Salem Rehab priors) (GARZA 000940-946)

Garza 9 (Lancaster Family Health) (GARZA 001333-1363)
Garza 10 (Salem Health prior 2015 surgery) (GARZA 001393-1555)
Garza 001575-1576 (4b-St. Moscati)
Garza Shoulder and Knee imaging from September 5, 2023

PDS provided 710 pages of records which were reviewed. I personally reviewed all of the imaging reports, available imaging disks, and medical records contained within this file. The records review language in this document attempts to quote wording exactly as it occurs in the original medical record. Errors of original syntax and grammar are duplicated as is. Although all records contained within the file were reviewed, the records review was focused on the clinical/medical conditions related to the injury claim only.

CHART REVIEW:

Miscellaneous Legal

May 17, 2022. Jason Kafoury. Complaint, Case No. 3:22-cv-00721. Demand For Jury Trial. Reviewed.

June 1, 2022. Letter from Adam Kiel to Richard Tobin, M.D. Reviewed.

Medical Record Review

April 2, 2015. Lazeni Koulibali, D.O. A 40-year-old male presents to the ED with worsening **right shoulder pain** for three days. Patient states he woke up three days ago with shoulder pain and it has continued to worsen. He denies any trauma to his shoulder. Patient notes the pain starts at his shoulder blade and radiates down his arm. **He reports he works as a barber and has not been able to cut hair**. Hypertension. Surgical history that includes back surgery and cystoscopy (February 15, 2014).

Physical examination tenderness on palpation to the right shoulder with **erythema, ecchymosis. Limited range of motion secondary to the pain. Diagnoses includes, but is not limited to; calcific tendinitis, bursitis, shoulder strain, fracture, and septic arthritis less likely.** We will proceed with x-ray to further evaluate and treat symptomatically. Robaxin, ibuprofen, and Norco for his pain at home. **Impression, acute right shoulder pain.**

April 2, 2015. Three views of right shoulder. There is no fracture, dislocation, or other acute osseous injuries seen. No lytic or destructive or blastic process is appreciated in the bones. No focal abnormality.

April 4, 2015. Peter Killefer, M.D. Five to six days of atraumatic right upper back pain that radiates to his neck and arm with no history of same per patient. Patient returns to ED for continuing pain without relief from these prescribed medications. He also complains of numbness in his thumb as well. **He states he is a barber and that he was unable to work today secondary to pain when lifting the right arm**. No asymmetry of the musculature of the back. Tenderness on the right upper back. The trigger point is around the rhomboid and trapezius musculature. No scapular winging. He is neurologically intact with no evidence of radiculopathy. There is very obvious trigger point in the right upper back causing muscle spasms. We discussed massages, cold compresses, and to continue with current pain medications.

Patient states that he thinks I am racist and withholding pain medications from him. I had a long frank discussion with him with the nurse (Val) and security standing by as observers and indicated that there was absolutely no racist intention in my interactions with him and that I treat all patients as I would have a family member treated. I indicated I was treating this muscle spasm with muscle relaxants and anti-inflammatories and that I did not believe that he needed narcotic further medications. **I did not broach with him his prior substance abuse issues noted in his Kaiser Care Everywhere chart notations.**

April 4, 2015. Diane Branson, RN. Patient returns with right upper arm pain - pain radiates to his neck and shoulder. Seen here "a couple of days ago." He has taken Vicodin two tablets and muscle relaxant already today. He states his right thumb and index finger are numb.

April 4, 2015. Sarah McMillen, RN. Patient has limited range of motion due to pain, currently unable to lift right arm away from side **(position of comfort)**. *[Reviewer's note: Position of comfort indicative of shoulder pathology.]*

Patient states "last time I was here they gave me a shot of Dilaudid and that took my pain away." The patient states "I am not comfortable with the level of pain I am having and I already have taken hydrocodone for pain and it did not even touch it." Patient then agreeable to take one tab Percocet when he advised that it is not the same drug as Norco. This RN requests the patient sign Patient Product Agreement form, so that SHED can bill either patient's insurance or bill patient directly for medical service. Patient then states "Oh, so you want the sling back." Advised the patient that I do not want to take the sling back and in fact that sling will likely help with **shoulder/arm discomfort**, but that the sling must be paid for either by insurance or out of pocket. Patient then states, "I see where this is going, you guys do not want to give me anything because you know I do not have insurance. That is why the doctor is not giving me the pain medicine that I need." "This is all just because the white doctor is helping the white guys."

April 7, 2015. Linda Nye, RN. Having severe right shoulder pain. Was told he has a strain here at the hospital. Patient has since been to a chiropractor who told the patient he has a herniated disk. He also does not want to see the last ED doctor because he did not like him. When I inquire if chiropractor did any x-rays, patient becomes very angry and states it does not matter if x-rays were done, we need to figure it out ourselves and take care of it. The patient states he was given 14 Vicodin and he took all of them within 18 hours because the pain was so bad. Patient came back when he had numbness. Patient then came to SHED and states **he is in 10/10 pain and his shoulder is swollen from the pain.**

April 7, 2015. Cervical spine MRI. Impression:

1. **Multilevel cervical disk degenerative disease.**
2. **At C5-6, there is a right paracentral and foraminal disk protrusion and uncovertebral joint hypertrophy resulting in moderate-to-severe right foraminal stenosis and right lateral recess narrowing. There is also mild-to-moderate left foraminal narrowing at this level.**
3. **At C6-7, there is a left foraminal disk protrusion resulting in moderate-to-severe left foraminal stenosis. There is also moderate right foraminal narrowing at this level.**
4. **At C4-5, mild right and mild-to-moderate left foraminal stenosis.**

April 8, 2015. Ryan Kirkpatrick, M.D. Patient is being seen at SHED twice previously for this pain and a chiropractor. Patient received a prescription for pain medication on his last visit and "I ate those up like candy." He does have a PCP, works as a barber. **Right shoulder pain, chief complaint.** Sitting up in bedside and chair. He has a sling on his right arm. Patient appears uncomfortable. **No pain with passive range of motion of right shoulder.** Male evaluated for pain in his right trapezius area. It starts at the base of the neck and goes down into his shoulder. He has some numbness in his right hand. **His pain is worse with intrinsic shoulder movements.** Other concerns include; muscle spasms, intrinsic shoulder problems. Symptoms are most suggestive of cervical radiculopathy. I offered MRI and he would like to proceed. Recommend the patient use steroids and pain medication. Follow-up with the neurosurgeon on call to see if they can offer any relief.

April 11, 2015. Lazeni Koulibali, D.O. Ongoing right arm pain with associated right thumb and index finger numbness. He states he has an appointment with a neurosurgeon in 1.5 months, but has run out of his pain medications. Tenderness to palpation of the right trapezius and right lateral arm. There is decreased sensation to light touch over the right thumb and index finger. Hand grip is symmetrical. He is here for pain control. Clinical impression, cervical radiculopathy, cervical spinal stenosis.

April 13, 2015. Peter Hakim, D.O. Presents to the ED with worsening right arm pain and right hand numbness. He states today the pain was so bad, "I took five Vicodin at one time and still did not do anything." **Patient reports improvement of pain with a shot of Dilaudid and Percocet.**

Anxious and uncomfortable appearing male. His right arm is in a sling. 5/5 strength. Good grip to intrinsic hand muscles, biceps and triceps. Subjective numbness to the thumb. Sensation is otherwise normal.

Patient was seen in ED numerous times in the past 11 days and I am concerned of the patient's use of pain medication, given his use of five doses at a time. **He appears at high risk for adverse events as he is already misusing his prescription that he has been prescribed. Patient has substance abuse issues noted in the Kaiser Care Everywhere, which increases the concern for substance abuse potential.** I informed the patient that it is Salem Hospital policy that we can no longer provide prescriptions for narcotic pain medications.

April 13, 2015. Jessie Pick, RN. Patient given prescription, states he will wait to see if MD has an additional MD for him to see. Patient decides to leave room, states, "I am going to see a lawyer, this is ridiculous." RN updated that I have not spoken with MD, patient throws arms in the air overhead and turns to walk out.

April 22, 2015. Sarah Acosta, RN. **Patient is barber and unable to lift right arm high enough to do work today.** *(Reviewer's note: Indicative of shoulder pathology.)*

May 4, 2015. Kathy Shaw, M.D. Chief complaint, established care. He reported neck pain, neck pain does not radiate. No neck stiffness. Tingling of the arms. Numbness of the arms. Patients states he woke up one day with acute neck pain. No history of trauma or fall. Patient continues to have right-sided pain that radiates down to his hand. **Patient admits that he has been buying narcotics from people who he knows to control his pain.** He reports that oxycodone has helped the best for him, he takes 5 mg and that helps him for about eight to nine hours. **Current smoker.** Assessment, cervical stenosis/stricture, cervicalgia, radiculopathy. Referral neurosurgery. Oxycodone, hydrochloride (oxycodone) 5 mg, one tab every eight hours for pain. Although discussed with patient that I will only fill narcotics times one month, if he needs additional pain meds, he will need to discuss with pain management clinic that I will also refer him to. I will give him oxycodone 5 mg t.i.d., #90 for 30 days. Discussed with patient that he must, STOP TAKING OTHER NON-PRESCRIBED NARCOTICS.

Bates numbered pages: Garza 573 through 578, poor legibility. Western Neurosurgery PC notations.

June 8, 2015. Jesse Hawkins, RN. Patient pale and stating pain is increasing, rating at 7/10 in neck, having to position neck to the right to get any relief.

June 8, 2015. Jerry Hubbard, M.D. Operative report. **Right C5-6 laminoforaminotomy, removal of herniated disk fragments, microsurgical technique.**

July 17, 2015. Lola White, Psy.D. The patient noted concerns around others in his environment taking advantage of his willingness to help and be supportive. **The patient reports a previous diagnosis of PTSD stemming from his neck injury**. The patient reported being troubled by a relationship with a woman. He reported confusion and frustration regarding whether she is his girlfriend, an employee, or a friend. The patient noted anxiety around feeling unable to voice his needs with her. The patient also noted frustrations with multiple individuals, who came into the shop, cause trouble, and often refuse to leave until he threatens to call the police.

Generalized anxiety disorder. The patient with generalized anxiety experiencing symptoms in response to interpersonal stressors and difficulty with appropriate boundary setting with others.

July 17, 2015. Kathy Shaw. Left knee pain and neck pain. Complaining of left knee pain with ambulation. Assessment, arthralgia of knee. Intervertebral cervical disc disorder.

July 23, 2015. Kathy Shaw. Complaint of pain medial side of left patella 2-3 months.

July 29, 2015. Lola White, Psy.D. Patient noted having significant anxiety and some depression following a neck injury. Patient did not have time for full appointment and agreed to schedule a follow-up appointment with BHC to address stress and mood management.

October 30, 2015. Mark Sauerwein, M.D. Here complaining of increasing left shoulder and arm pain with coolness of fingertips left side.

December 18, 2015. Neck and left arm pain. History of surgery. Pain into 1st and 2nd fingers.

February 5, 2016. Erik Blake, M.D. **Chief complaint of left-sided neck, shoulder, and arm pain.** He also has numbness and tingling on the left hand into the first three digits of the left hand. He noticed that the first two digits are primarily affected with tingling. The patient has a past history of cervical problems. In April of 2015, he had right-sided neck and arm pain as well as numbness of the right thumb. His cervical MRI revealed that he had a right-sided C5-6 disk herniation impacting on the C6 nerve root. The patient

underwent surgery by Dr. Hubbard on June 8, 2015. This was a microsurgical right-sided C5-6 laminoforaminotomy with removal of herniated disk fragments. Following the surgery, the patient did well, with resolution of his pain. **He has some residual partial numbness in the right thumb, but otherwise he was doing fine, and he was able to get back to working as a barber. Unfortunately, he developed pain in the left side of the neck and the left shoulder and down the left arm along with numbness and tingling in the left upper extremity in early October 2015. He had a repeat cervical MRI on December 16, 2015. This was notable for showing severe left C6 neural foraminal narrowing. It was recommended that the patient have surgery, but he declined. It was noted by Dr. Hubbard that the patient was more interested in trying to get disability than to have curative surgery.** The patient was prescribed a prednisone taper and was also given a prescription for Soma.

The patient complains of a constant pain that is felt at the left side of the neck, in the left shoulder, and radiating down the left arm all the way to the hand. **Due to the severity of his pain, he states he has had to stop working as a barber.** He states that he is depressed about his situation because of his inability to work. **He does not feel that there is any type of work that he can do, and he feels that he should be on Disability.** His pain is increased when his left arm is elevated, when he is lying down, or when he turns his neck toward the left side. **He does not have any new right upper extremity symptoms.**

There is no tenderness along the cervical spine or over the right-sided cervical paraspinal muscles. There is pain to palpation over the mid to lower left-sided cervical paraspinal muscles. There is pain to palpation over the left upper trapezius muscles without tenderness over the right upper trapezius. Kennedy-Hawkins impingement test is negative at the left shoulder. Spurling's test is strongly positive to the left, reproducing the patient's typical symptoms within a matter of seconds. **He is able to tolerate elevating the left shoulder only to about 90 degrees of abduction before he complains of experiencing too much pain.** There is give-way with testing of the left shoulder abduction strength, and this seems to be due primarily to pain associated with testing. **Sensation is subjectively decreased to pinprick throughout the entirety of both hands, but sensation is intact throughout the remainder of the upper extremities.** I explained to him that he appears to have compression of the left C7 nerve root within his spine. **Because of his current symptoms, he says that he is unable to work, and he feels that he should be on disability.** I told him that cervical surgery could potentially eliminate all of his symptoms that he has in the left upper extremity, and he would then be able to return to his prior work as a barber. The patient says that he is worried that surgery will not be fully helpful, given that he still has some partial numbness in the right thumb. I explained to him that it is possible to experience permanent nerve damage from a herniated disk, but there can be nerve regeneration for up to approximately 18 months

after the onset of neural insult. I told the patient that he should reconsider cervical surgery given this potentiality could substantially decrease his symptoms and allow him to get back to work. The patient wants to refrain from surgery if at all possible. We will refer to Dr. Anderson.

The patient agreed to try nortriptyline, and therefore I sent in a prescription for nortriptyline 25 mg to be taken one to two capsules at bedtime.

I told the patient that a physician in Oregon cannot declare a person to be disabled. Disability is something that is determined through the State Disability Services. **I told him that I suspect that he would have difficulty being put on Disability.** At this point, I discharged the patient from my care since there is nothing else for me to offer.

February 24, 2016. Kathy Shaw, M.D. Presents for evaluation of neck pain, new left-sided pain.

June 13, 2016. Kathy Shaw, M.D. Neck pain that now radiates down his left arm. **Requesting a letter stating that he has been unable to work**.

June 21, 2016. Viven Valdez, D.O. Primary complaint of left neck and left arm pain. The limb pain is described as 100% above the elbow. The onset of pain began suddenly with no apparent cause. The patient is currently unemployed as of April 14, previously worked as a barber. [*Reviewer notes that medical record says framer.]* The pain is aggravated by "moving neck to a certain degree." **He reports approximately 50% reduction of pain in general with medical marijuana. Patient states he feels angry, sad, and tense and worries all the time.** Shoulder flexion 110 degrees produces left upper extremity radicular pain. Shoulder abduction 160 degrees, right shoulder. Left shoulder 50 degrees reproduces radicular pain. Left triceps 4/5. Decreased left supraspinatus and left deltoid sensation. Decreased left triceps, left forearm, left medial forearm, left first digit, left third digit, left fifth digit sensation. Neck rotation left 10 degrees reproduces radicular symptoms, rotation right 80 degrees. Spurling's positive left. Reflexes biceps right 2/4, left 2/4; triceps right 0/4, left 0/4. Brachioradialis right 1/4, left 0/4. Assessment, cervical radiculopathy, neural foraminal stenosis of cervical spine, cervical spondylosis with radiculopathy, cervical myofascial pain syndrome, neck pain, **pain disorders related to psychological factors**, anxiety state, depression. Symptoms and exam are consistent with cervical radiculopathy affecting the left C5, C6, C7 dermatomes; exam noted with correlative sensory changes, subtle motor deficits, neural tension signs, and reflex changes. We will plan for left C4-5, C5-6 transforaminal epidural steroid injection.

Bates number pages: Garza 543 through 551. Salem Pain and Spine Specialists illegible.

June 29, 2016. Rebeca Monreal, D.O. Left C4-5, C5-6 cervical transforaminal epidural steroid injection.

August 2, 2016. Viven Valdez, D.O. Left C4-5, C5-6 cervical transforaminal epidural steroid injection on June 29, 2016, for cervical radicular pain. He reports approximately 15 to 20% transient relief of the neck, shoulder, and arm pain. Today, **the patient reports approximately 0% improvement in pain.**

Discussed the treatment options, I do not have any further interventional spine procedures to offer at this time. He has referral sent in for neurosurgical evaluation with Dr. Hatchette. **Additional findings today of right third digit trigger finger**.

September 21, 2016. Robert Zirschky, M.D. Multiple musculoskeletal complaints, specifically today we are talking about his hands. His right hand in particular has significant problems with triggering and catching of the middle finger. **He has significant pain and weakness of the thumb.** He also has significant pain and swelling around the DIP joint of his small finger on the right hand. His main complaints though are triggering of the middle finger, stiffness and pain of the right thumb and small finger and swelling and pain at the PIP joint. He has failed back surgery apparently and is undergoing workup for his neck with some radicular pain down into his left arm as well as pain in the right arm and shoulder area. He again is undergoing chronic pain treatment and evaluation. The patient is right-handed.

He has some restrictions in cervical motion and cervical motion reproduces pain into the neck and upper arm area, but not down into his hand today. Spurling's test again produces again discomfort into the shoulders and upper arms. There is moderate prominence on the right-hand basal joint with marked tenderness and positive grind test. There is decreased pinch strength also on the right hand compared to the left. Grip strength is also diminished. There is triggering of the middle finger of the right hand and tenderness of both of the middle and ring finger flexor tendons at the MP joint volarly. It appears though his middle finger extensor mechanism also slightly subluxes during finger extension. The left hand again has full movement with just tenderness at the basal joint. Assessment, trigger middle finger of right hand. Recommended course of therapy directed at a bracing and exercise program for his hand. **Primary arthritis of first carpometacarpal joint of right hand.**

September 21, 2016. Right hand three views. X-ray of right hand shows moderate basal joint subluxation, flattening of the trapezium and mild sclerosis, though the joint space is still fairly well preserved. There is no additional bony abnormality noted.

September 21, 2016. Jennifer Malone. Right hand custom brace exercises for one to two visits.

January 25, 2017. Christine Bunjter, RN. Patient states that he awoke a few days ago and he had severe neck pain from broken bones in his neck. States he never had an injury, but he is in severe pain today. **Patient points to the right side of his neck and states that two days ago, he felt two more bones break off in the right side of his neck, 10/10.**

January 25, 2017. Alexander Nelson, PA. The patient eloped prior to my evaluation, and I was unable to obtain a history and perform an exam. Efforts were made to track him down, but he left the department without warning.

April 28, 2017. Maya Modzelewska, M.D. **He reports bilateral neck pain, that radiates into his shoulders and down both arms to the hands.** He reports that 50% of the pain is in the neck and shoulders and 50% of the pain is in his arms, 50% is above the elbow and 50% is below the elbow. This pain is similar to the pain he had during his last visit, at which time he did not respond well to a cervical ESI and was sent to neurosurgery, but **he had a lapse in insurance coverage, so he did not see neurosurgery.** He also complains of diffuse pain throughout his back, shoulders, hands, knees, low back, and thinks that **"his joints are coming out of place." The pain is debilitating and reports that he takes four hours to get out of bed sometimes.**

Since our last visit, he said that he had gone to jail for 10 days, and he was taken off all his medication and reports subsequently having an MI. He reports prior use of Cymbalta was helpful for his mood and to a degree with his pain. He is interested in restarting his medications. **He is requesting narcotic pain medication and admits to recently purchasing Percocet off the streets, which he reports he plans to continue to do unless provided with opioid pain medications.**

Cervical rotation, flexion, extension and lateral bending are all limited and reproduce axial neck pain. **Bicipital tendon tender bilaterally.** Trapezius tender to palpation bilaterally. **Shoulder active range of motion limited.**

Christopher has ongoing complaints suspicious for cervical radiculopathy with significant diffuse myofascial neck and shoulder pain. He will be referred back to Salem Spine Center to consult with neurosurgery. He will be started on Cymbalta. **The patient appears very anxious at today's exam and may benefit from establishment with a mental health provider to address both his mood as well as his coping with chronic pain.**

May 9, 2017. Kathy Shaw. He reports his neck, back, and shoulder pain is still his biggest concern. He states he was in jail for about 10 days and taken off all his meds. He saw Dr. Modzelewska at Salem Spine and Rehab about 2 weeks ago and was restarted on Cymbalta. **At that time he admitted to obtaining Percocet off the street to help with his pain.** He also smokes marijuana for the pain but denies any other illicit drug use.

May 10, 2017. Lola White, Psy.D. Patient endorsed depressed mood, anhedonia, psychomotor retardation, fatigue, feelings of worthlessness/guilt and difficulty concentrating, which had been present for the past month. The patient stated he was in jail this last month and taken off all his medication. The patient disclosed having panic attacks shortly after his release, but none in the past two weeks. **The patient stated he had been trying "blow" to help with mood. Discussed how stimulants can increase anxious and panicky symptoms**. The patient did not respond to questions about when he last used. The patient's primary concern today was pain. Discussed non-pharmacological approaches to pain management. Patient expressed openness to trying MidValley Pain Clinic.

June 27, 2017. Kathy Shaw, M.D. Four-year history of worsening neck, shoulder, and upper extremity symptoms. He has chronic neck pain, pain and tingling in his shoulders and arms bilaterally and constant numbness in the digits 1, 2, 3 of both hands. On exam, strength is intact throughout the entirety of the upper extremities. **Sensation is subjectively decreased to pinprick everywhere in the upper extremities, except at the extensor right forearm.**

All nerve conduction studies were within normal limits. Impression,

1. Abnormal study.
2. **Electrodiagnostic evidence of a remote left C7 radiculopathy.**
3. **No electrodiagnostic evidence of an acute or subacute left or right cervical radiculopathy.**
4. No electrodiagnostic evidence of left or right brachial plexopathy.
5. No electrodiagnostic evidence of a left or right median neuropathy.
6. No electrodiagnostic evidence of a left or right ulnar neuropathy.

September 19, 2017. Jeffrey Daniel, PA-C. Presents today with a myriad of several complaints, patient appears to be very stressed throughout appointment today. The patient is very upset that he is in pain, states no one is being able to help him with this pain. When questioned patient was able to schedule follow-up with pain management. He states that he had one appointment, but he was advised that he did not need any more appointments. **This is contrary to note with pain management, pain management states that patient was seen in clinic Christopher advised them that he can control the pain on his own and he did not want to continue with following up appointments**

with them. The patient describes pain in his neck that is radiating into his left shoulder and down into his arms and his left wrist.
The patient has full range of motion in cervical vertebrae, the patient has full range of motion in left shoulder, unable to examine the patient's wrist in due to it being in a brace, the patient is very upset during examination, states several times that he just wants to leave. At several points throughout the appointment, I asked what his goals are for his neck pain, the patient is unable to give a clear answer and starts complaining of other issues.

December 6, 2018. Taylor McDowell, PA. Cellulitis of left knee. Area is spontaneously draining today. Bactrim every 12 hours for 10 days. Chronic pain syndrome. Patient requests Soma, stating this is the only thing that works for him. I do not prescribe Soma, but the patient is adamant this is the only thing that will work for him. He requests to be referred to a pain specialist. I think he would be a good candidate for pain management elsewhere. Chronic pain per patient is from **"botched spinal surgery."**

Patient reports he is disabled because chronic left knee pain, "nerve damage to hand" history of MI, recurrent skin infections. Neck surgery, lower back surgery **(he reports the doctor did the surgeries wrong)**. Recommended to be seen by Orthopaedics. Severity of problem is moderate. Left knee erythema, range of motion; spontaneously draining abscess.

December 6, 2018. Left knee radiographs. Pre-patellar soft tissue swelling.

December 7, 2018. Northwest Human Services. No author identified. Patient with chronic left knee pain, was told at one point, it was his meniscus. No record so far for this patient. He would like to be evaluated by Ortho. **Getting x-rays today and treating for left knee cellulitis with Bactrim.**

December 11, 2018. Seth Alkire, M.D. A 44-year-old man with history of tobacco abuse, chronic low back pain status post lumbar fusion of L3 and L4, chronic cervicalgia status post fusion of C5-6 many years ago with subsequent chronic pain syndrome, presents to establish care. Primarily concerned with his cervicalgia.

May 21, 2020. Seth Alkire, M.D. Chronic right shoulder pain. MRI shoulder right without contrast; **future**. *[Reviewer's note: Of the five pages of medical records all but this paragraph is blocked out in the clinical notations.]*

December 28, 2020, page number Garza 430. Seth Alkire, M.D. Chronic right shoulder pain. MRI, shoulder right. Future. **Refer to physical therapy.** [*Reviewer's note: Poor legibility follows]*.

Bates numbered pages Garza 428 through 430: Poor legibility. *(Reviewer's note: Please request better quality copies.)*

April 27, 2021. Juan Castillo, DNP. **Abdominal pain, right shoulder pain, and left knee pain. Right shoulder pain, duration more than one hour, severity level is mild. It occurs intermittently and is worsening. The pain is aggravated by lifting, movement, and pushing. The pain is relieved by ice and massage.** Associated symptoms including tingling in the arms and weakness. **Shoulder right tenderness, range of motion moderate pain with motion.** Anxious, inappropriate mood and affect – depressed. **Further diagnostic evaluations ordered today include x-ray shoulder complete two views.**

Assessment, **acute pain of right shoulder. Physical therapist to evaluate and treat.**

September 17, 2021. Juan Castillo, DNP. Right shoulder pain. Occurs constantly and is worsening. There is an injury. **Twisted/pivoted occurred in a public building, two days ago on September 15, 2021.** The pain is aggravated by lifting and movement. Associated symptoms include crepitus, decreased mobility, joint tenderness, popping and weakness. **Patient reports he was working on his car when police officer showed up and arrested him causing harm and injuring his shoulder, states shoulders were hyperextended when he was being arrested, states he was later released once they found out it was his vehicle and he was not stealing it.** Shoulder left tenderness, range of motion mild pain with motion. Right shoulder tenderness, range of motion; mild pain with motion. Assessment, right anterior shoulder pain.

September 20, 2021. Left shoulder radiograph. Left shoulder negative.

September 20, 2021. Right shoulder radiograph. Right shoulder negative.

September 24, 2021. Juan Castillo, DNP. **Right shoulder pain**. It occurs constantly and is worsening. The pain is aggravated by lifting and movement. Right shoulder tenderness, range of motion; moderate pain with motion.

October 4, 2021. Richard Tobin, M.D. Bilateral shoulder pain, right greater than left. The pain started on a couple of weeks ago, when he was in a parking lot, whenever a policeman came over to him because he thought he was stealing a car and was rough with his shoulders and pulled them, which is when the pain began. Reports bilateral shoulder pain. **Associated symptoms include radiates down to hand on the right, pain radiates down to thumb and keeps him up at night. He denies any previous issues with his shoulder.**

He was seen here in 2016, to see Dr. Zirschky, and complained of right shoulder pain. He states he has always had soreness, never the pain he has now. **In April 2021, he saw a doctor for his right shoulder as well.** Right shoulder exam, forward elevation 80 degrees. Abduction 80 degrees. External rotation 80 degrees. Inward rotation to 75 degrees. Adduction 40 degrees. Extension 60 degrees. External rotation with the elbow at the side 30 degrees. No evidence for instability. Negative impingement signs, positive load compression test, positive painful arc, negative drop arm test, positive O'Brien's test, Speed's, and Yergason's, cross-arm test. Strength is 5/5 with pain and resisted external rotation. Tenderness over the posterolateral aspect of the shoulder and over the joint line.

Left shoulder exam, forward elevation 150 degrees. Abduction 145 degrees. External rotation 90 degrees. Inward rotation to 75. Adduction 40 degrees. Extension 45 degrees. External rotation with the elbow at the side 25 degrees. No evidence for instability. Skin is intact, warm and dry without atrophy or wasting. No tenderness to palpation about the shoulder.

Middle-aged gentleman who was assaulted by police and complains of bilateral shoulder pain, right greater than left. **He does have some previous issue of right shoulder problems, which are documented with an x-ray and the PAC system. He states that this is worse**. At this point, we need to rule out a rotator cuff tear. We are going to order an MRA because it may also be a labral issue. His exam is notable for pain, behavior, and signs of a rotator cuff tear, as well as a labral tear. This was secondary to police "roughing him up."

October 29, 2021. Kevin Bell. Right shoulder MRA injection.

October 29, 2021. Right shoulder MRA. Impression:

1. **Nondisplaced tear throughout the superior labrum into the cephalad aspect posterior superior labrum where there is a small to moderate, lobulated paralabral cyst.**
2. **Mild supraspinatus, infraspinatus, and subscapularis muscular atrophy.** *[Reviewer's note: Atrophy indicates chronicity.]*

November 1, 2021. Richard Tobin, M.D. Presents for right shoulder MRI results. Worsening right shoulder pain. He rates it as 8/10. Associated symptoms include **pain into the neck**. His symptoms are exacerbated by reaching. Assessment, SLAP lesion of right shoulder. Primary osteoarthritis, right shoulder.

My impression is he has a labral tear, AC joint arthritis, and a possible tear in the rotator cuff in the right shoulder. At this point, I offered him conservative versus more aggressive options. He wants to proceed with arthroscopic labral repair and

decompression and possible distal clavicle excision. If there is a rotator cuff tear, I told him I will repair it. Prescription hydrocodone.

November 29, 2021. Juan Castillo, DNP. History of present illness, hypertension, anxiety, right shoulder pain, and PTSD.

December 5, 2021. Elise Blinder, M.D. The patient states he has had weeks of constant chest pain. The patient states he notices this more when he is upset and anxious. Being worked up for a mildly abnormal EKG in the setting of a planned orthopaedic surgery.

December 7, 2021. Richard Tobin, M.D. Post-operative diagnosis, degenerative labral tearing, paralabral cyst with impingement and partial thickness tear of rotator cuff, right shoulder.

Procedure:

1. Examination under anesthesia.
2. Diagnostic arthroscopy.
3. Arthroscopic debridement of labrum, trephination of cyst with subacromial decompression and debridement of partial thickness tear, right shoulder.

Operative findings, on diagnostic arthroscopy, he had some fraying of the labrum. **He did not have a frank SLAP type II**. We went ahead and trephinated the area of the paralabral cyst and got return of some fluid and debrided the labrum in this area as well at the posterior-superior aspect. The rotator cuff had a small partial thickness tear with fraying of the inner layer of the anterior supraspinatus. On the bursal space, there was a lot of bursal tissue. I went ahead and debrided this. The cuff itself appeared to be intact.

December 17, 2021. Kevin Bell, PA-C. First post-operative visit for his right shoulder. Today rates his pain 4 to 8/10, depending on what he is doing. He is taking oxycodone 1 to 2 pills every six hours for pain relief. We will give the patient a final refill of oxycodone (40 pills) and then get therapy ordered.

August 22, 2022. Juan Castillo, DNP. Anxiety. There is worsening of previously reported symptoms. The patient reports functioning as somewhat difficult. The patient presents with anxious/fearful thoughts, depressed mood, difficulty concentrating; diminished interest or pleasure and excessive worry, but denies thoughts of death or suicide. The patient reports he continues to have anxiety due to PTSD and is afraid to leave home due to "a run in with the police." **Patient states his mom was visiting and she gave him lorazepam one time and it helped him for three days, would like prescription for this, discussed treatment options and discussed addiction.**

Physical Therapy

Records reviewed November 28, 2016 through January 27, 2022.

January 27, 2022. Elizabeth Horner. The patient notes show two appointments. He has not returned phone calls. Due to attendance all appointments are being cancelled. If he would like to continue PT, he will need to talk to the therapist.

IMAGING REVIEWED:

December 6, 2018. Left knee radiographs.

April 28, 2021. Right shoulder three radiographs. Acromioclavicular joint degeneration.

September 20, 2021. Left shoulder three radiographs. No fractures or bony abnormalities.

September 20, 2021. Three views right shoulder. Acromioclavicular degeneration.

October 29, 2021. Right shoulder MRA. Reviewed.

9 Undated, and unidentified arthroscopic images were reviewed. File 12-7-21

September 5, 2023. Right shoulder three radiographs. Mild acromioclavicular joint osteoarthritis. Otherwise unremarkable.

CONCLUSIONS:

The following represents my professional opinion based upon the review of the materials listed. If more information becomes available at a later date, an additional report may be requested. Such information may or may not change the opinions rendered in this evaluation. I reserve the right to amend this report if other evidence becomes available. Comments on appropriateness of care are professional opinions based upon the specifics of this case and should not be generalized, nor necessarily be considered supportive or critical of, the involved providers or disciplines. All of my opinions expressed are on a medically more probable than not basis. The Reviewer's opinions are based upon reasonable medical certainty and are impartial.

Any medical recommendations offered are provided as guidance and not as medical orders. The opinions expressed do not constitute a recommendation as specific claims or administrative action be made or enforced.

DIAGNOSTIC IMPRESSION:

1. Hypertension, prior lumbar surgery, cystoscopy, prior substance abuse, narcotic abuse, marijuana use, tobacco use, left knee abscess (prior to lumbar surgery 2006), prior incarceration, anxiety, depression, left knee pain, history of disabled physical status, right third, fourth digit trigger finger, osteoarthritis first CMC joint right hand, pre-existing unrelated to events of September 17, 2021.

2. Cervical degeneration with right C5-6 lateral recess narrowing secondary to disc protrusion, right foraminal stenosis, left C6-7 foraminal stenosis, and right C4-5 foraminal stenosis, pre-existing, unrelated to events of September 17, 2021.

3. Status post cervical laminoforaminotomy C5-6 (June 8, 2005), pre-existing, unrelated to events of September 17, 2021.

4. Cervical left-sided radiculopathy with upper extremity symptoms and severe disability, pre-existing, unrelated to events of September 17, 2021.

5. Chronic back, shoulder, hand, knee, low back pain, pre-existing, unrelated to events of September 17, 2021.

6. Right shoulder pain secondary to shoulder degeneration, pre-existing (2020), unrelated to events of September 17, 2021.

7. Status post arthroscopic debridement of labrum, trephination of cyst with subacromial decompression and debridement of partial thickness rotator cuff tear right shoulder, December 7, 2021, unrelated to events of September 17, 2021.

This report was prepared by me and is true and correct to the best of my knowledge. The opinions and conclusions stated therein are more-probable-than-not based upon reasonable medical probability.

I, Tom Faciszewski, MD, MBA declare under the penalty of perjury under the laws of the State of Washington that the following is true and correct:

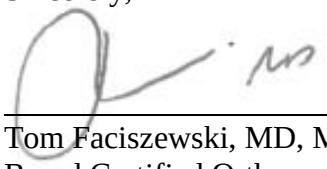
1. I am over the age of 18 years, I am competent to testify, and have personal knowledge of the facts contained herein in this declaration.

2. I declare that the attached report of Christopher Garza was prepared by myself and is true and correct to the best of my knowledge.
3. I reviewed Christopher Garza's medical records.

4. The opinions and conclusions stated herein are stated on a more-probable-than-not basis and to a reasonable degree of medical certainty.

Thank you for allowing me to participate in the evaluation of this particular individual. If I can be of any further assistance, please contact me through Physician Direct Services.

Sincerely,



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Board Certified Orthopaedic Surgeon

CERTIFICATIONS: American Board of Orthopaedic Surgery
December 31, 2025

LICENSES: Idaho, Oregon and Washington

POST GRADUATE EDUCATION:

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Fellowship-Spine Surgery
1992-1993
Minnesota Spine Center
606 24th Avenue South, Suite 606
Minneapolis, Minnesota 55454-1419

Residency-Orthopedic Surgery
1988-1992
University of Utah Medical Center
50 North Medical Drive
Salt Lake City, Utah 84132

Internship-General Surgery
University of Utah Medical Center
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Salt Lake City, Utah 84132

EDUCATION:

M. D.
1987
University of Colorado School of Medicine
4200 East 9th Avenue
Denver, Colorado 80262

B. A. Biology	Grinnell College
1983	Grinnell, Iowa 50112
H.S. Diploma	Iver C. Ranum High School
1979	Denver, Colorado

AWARDS AND HONORS:

North American Spine Society:

2012	David Selby Award for contributing greatly to the art and science of spinal disorder management through service to NASS

University of Colorado School of Medicine:

1987	Graduated with Honors
1987	Willard A. Smith Scholarship
1986, 1987	Alpha Omega Alpha

Grinnell College:

1983	Graduated with Honors
1983	Phi Beta Kappa
1981, 1982, 1983	Dean's List

TEACHING POSITIONS:

University of Colorado School of Medicine
Department of Anatomy
Anatomy Assistant and Tutor
1983-1984

LOCAL POSITIONS:

Vice President and CMO of Supply Chain
St. Luke's Health System
Boise, Idaho
2014- 2016

Orthopedic Spine Surgeon

Marshfield Clinic
Marshfield, Wisconsin
1993-2013

Chairman
Department of Orthopedic Spine Surgery
Marshfield Clinic
1997 - 2012

Medical Director of Supply Chain
Ministry Health Care
2007 – 2012

Medical Director of Supply Chain
St Joseph's Hospital
2005 – 2012

Medical Director of Spine Surgery
Marshfield Clinic
2008 – 2010

Assistant Medical Director of the
Operating Room
St Joseph's Hospital
2005 – 2012

Medical Director of Orthopedics
St Joseph's Hospital
2007 – 2009

Chairman, Department of Orthopedics
Marshfield Clinic
Jan. 2007 – Sept. 2008

Member Physician Steering Committee
Healthtrust Purchasing Group (HPG)
2009 - 2011

STATE AND NATIONAL ORGANIZATIONS:

North American Spine Society (NASS)
Idaho Medical Association (IMA)
American Academy of Orthopaedic Surgeons (AAOS)

STATE & NATIONAL COMMITTEES:

Idaho Medical Association
Medical Review and Advisory Committee
2018-current

Conflict of Interest Review Committee
NASS
2009 - 2013

Spine Panel Reviewer
2002- 2013

The Spine Journal Associate Editor
2002 – 2010

Medical Director of Orthopedics
St Joseph's Hospital
2007 – 2009

Co-Chair of the NASS Nomenclature for Degenerative Disc Disease Task Force
2007 – 2009

Medicare Coverage Advisory Committee
2007 - 2009

NASS Board of Directors
1ST Past President
2008 – 2009

NASS Board of Directors
President
2007 - 2008

NASS Board of Directors
1st Vice President
2006 - 2007

NASS Board of Directors
2nd Vice President
2005 - 2006

Annual Meeting Site Selection Committee
(NASS) 2004 – 2006
NASS Board of Directors
Secretary
2003 - 2005

National Association of Spine Surgeons (C6) Chairman, Washington Committee
Washington, D.C. 2001, 2002, 2003, 2004, 2005

Board of Directors, Board Member
Socioeconomic Affairs Council, Director
North American Spine Society (NASS)
2000 – 2003

AMA Current Procedural Terminology (CPT) Advisory Representative for NASS
1998, 1999, 2000, 2001

NASS Annual Meeting Program Committee Member

1998, 1999, 2001

SRS Nomenclature & Coding Committee-Member
1995, 1999, 2000, 2001

NASS Annual Meeting Program Committee Chairman
2000

NASS Editorial Board, *SpineLine*
2000

AAOS Coding and Reimbursement Committees, Representative for NASS
1998, 1999, 2000

NASS Nomenclature and Coding Committee-Chairman
1997, 1998, 1999, 2000

NASSNews Subcommittee-Chairman
1996, 1997, 1998, 1999

Medical Editor NASSNews
1996, 1997, 1998, 1999

NASS Nomenclature and Coding Committee-Member
1994, 1995, 1996

PUBLICATIONS:

E. Bailey Terhune, BS, Peter C. Cannamela, BS, Jared S. Johnson, MD, Charles D. Saad, BS, John Barnes, MBA, Janette Silbernagel, RN, Thomas Faciszewski, MD, and Kevin G. Shea, MD
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Delivers message to congress on Capitol Hill Day, "Fix the Formula"
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PRESENTATIONS: Supplied upon request

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Tom Faciszewski MD MBA trial and/or deposition case list history:

1) Independent Medical Examination expert opinion- Idaho Industrial Commission, Steven H. McConnell vs. AutoZone, Employer, and New Hampshire Insurance Company, Surety, I.C. No. 2012-013368, 2017

2) Independent Medical Examination expert opinion-Idaho Industrial Commission, Dale Shaw v. Caldwell Transportation Company, Employer, and the Idaho State Insurance Fund, Surety, I.C. No. 2015-012378, 2018

3) Independent Medical Examination expert opinion-Idaho Industrial Commission, Mark Hopper vs. Glanbia Foods, Employer, and American Zurich Insurance Company, Surety, I.C. No. 2014-025563, 2021

4) Independent Medical Examination expert opinion-Idaho Industrial Commission, Randy Larkin vs. Fluor Idaho, LLC, Employer, and New Hampshire Insurance Company, Surety, I.C. No. 2017-054413, 2021

5) Independent Medical Examination expert opinion-Idaho Industrial Commission, Joseph McCullough vs. Glanbia Foods, Employer, and American Zurich Insurance Company, Surety, I.C. No. 2018-026619 and I.C. No. 2018-016751, 2021

6) Records review expert opinion-Ada County Idaho District Court of the Fourth Judicial District, Small Lawsuit Resolution Act, Tammie & Chloe Rudorf vs. Julie Olson, Case No. CV01-21-12630, 2022

7) Records review expert opinion, Marion County Courthouse, Robbie Warmack v. City of Salem, Case No. 20CV21254

Physician Direct Services

406 Yauger Way SW Suite A
Olympia WA 98502
Phone:360-867-4188 Fax:360-867-0466
TAX ID #: 35-2618335

Case Nbr: 20523002590

TOM FACISZEWSKI MD
4102 WEST HOUSELAND COURT
EAGLE, ID 83616

Claim Nbr: 3:22-cv-00721-HZ
Examinee: Garza, Christopher
Provider: TOM FACISZEWSKI, MD Orthopaedic Surgeon

VOUCHER

Date	Description	Amount
7/5/2023	CONFERENCE	375.00
7/5/2023	RECORD REVIEW	3,375.00
	Total:	3,750.00

Independent Orthopedic Services

INDEPENDENT ORTHOPEDIC SERVICES, PLLC
Dr. Tom Faciszewski, MD, MBA
7979 W. Rifleman St.
Boise, ID 83704
Phone number: (208)-989-5242

IOS GENERAL TERMS AND CONDITIONS

*Records to be delivered to IOS organized in **chronological order of treatment**. (Please separate out PT and Chiropractic notes and place in two additional separate sections at the end of the medical records)*

Fee Schedule

Independent Medical Evaluation (Single body-part injury)-**Liability**	$2000
Exam room fee	$100
Each additional body-part injury evaluation	$250
Each additional date of injury (DOI)	$500
Rush Fee (for 24-hour turnaround for report)	$500
Additional Records Review (if file >1 inch in thickness or unorganized)	$750/hour
Case/Record Review (i.e. expert witness, record review only)	$750/hour
Recording of appointment by examinee (requires a professional audio/videographer, and a copy provided to IOS)	$300
Travel expenses outside of Ada or Canyon Counties	$750/hour + expenses

Depositions/Trial Testimony

2-hour minimum for Deposition (incl. time per hour portal to portal)	$800/hour
3-hour minimum for Trial Testimony (incl. time per hour portal to portal)	$800/hour
Mileage if outside of Ada or Canyon Counties	$.625/mile
Travel expenses outside of Ada or Canyon Counties	$800/hour + expenses

Policies:

Late fee may be assessed if records are not received 10 business days prior to appointment.
Cancellation prior to 10 business days: Records reviewed prior to cancellation will be billed at the hourly rate and the balance will be refunded.
Cancellation within 10 business days or no show: Non-refundable.
Patients more than 15 minutes late will be considered no shows.
Deposition/Trial Testimony: Payment is due at time of scheduling. Cancellation within 30 days is non-refundable.

Thank you for choosing IOS!

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

CHRISTOPHER GARZA, Plaintiff, v. CITY OF SALEM, an Oregon municipal corporation; and OFFICER DAVID BAKER, an individual, Defendants.	Case No. 3:22-cv-00721-HZ

FEDERAL RULES OF CIVIL PROCEDURE 26(a)(2)(B)
EXPERT REPORT

In compliance with FRCP 26(a)(2)(B), I hereby certify that this report is a complete and accurate statement of my opinions and the basis and reasons for them, to which I will testify under oath.

DATED: September 22, 2023

Brian Harvey
Harvey Risk Mitigation and Training

Expert Report and Opinions

RE: Christopher Garza v City Of Salem and Officer David Baker

My name is Brian Harvey and I have been retained by Mr. Sebastian Tapia to review the material provided in this matter and offer objective opinions within my area of police practice and expertise concerning the decisions made by Officer David Baker during his interaction with Mr. Christopher Garza on September 17, 2021.

I reached the conclusions by reviewing the material provided and drawing upon the knowledge, training, research and experience gathered during my 37 years of full time sworn police career. My rule 26 (B) disclosures are listed on attachment B. The material reviewed is listed on Attachment A. My educational background, training, operational experience and qualifications are listed on Attachment C. Upon this review and consideration I offer the following opinion in reference to this incident.

I reserve the right to change or modify my opinion based on new or additional information that is presented to me.

Opinion

I offer the following opinions related to my area of police practice and expertise. My opinions are offered to a reasonable degree of professional certainty and based on the materials reviewed, information considered, and conclusions drawn from the case material and totality of my knowledge, training and experience.

Opinion 1

It is my opinion and belief that the detention and force used by Officer David Baker was consistent with contemporary police training, standards and practices for a reasonable, prudent and properly trained officer facing similar circumstances.

Opinion 2

The stop Officer Baker made was based on what a reasonable, prudent and properly trained officer would perceive to be reasonable suspicion that a crime had been committed or was about to be committed.

Opinion 3

The length of the detention and investigative actions taken during the detention of Mr. Garza was consistent with what a reasonable, prudent and properly trained officer would conduct for an investigative stop in like circumstances.

Incident Summary

On September 17, 2021 at 12:38 AM, Salem Police Department Officer David Baker contacted three men at a closed business at 2305 Commercial St. NE, Salem, Oregon. Officer Baker spotted Christopher Garza sitting inside a Honda Accord car with the door open and two other men standing outside the car looking toward the engine. Officer Baker noted there was a closed sign on the business and the car appeared dusty in

appearance. He believed it was possible the men were attempting to steal the car or items out of the car[1].

When Officer Baker started to approach the men, Mr. Garza exited the car and walked toward Officer Baker. Officer Baker said hi to the men and asked them what was going on. Mr. Garza told him he didn't need to be there and to leave. Officer Baker described Mr. Garza's demeanor as very confrontational. Mr. Garza told Officer Baker that he worked there and that Officer Baker was trespassing and needed to leave. Officer Baker asked Mr. Garza for ID to verify he worked there and Mr. Garza walked away from Officer Baker and towards the car[2].

Officer Baker ultimately proceeded to attempt to detain Mr. Garza who walked away from Officer Baker then physically tried to pull away while Officer Baker was placing him in an arm/shoulder lock and handcuffing him[3]. Officer Baker placed Mr. Garza into the back of his patrol car while he conducted a brief investigation where he determined that Mr. Garza did live at the location and was not attempting to steal anything. He then released Mr. Garza and did not see any apparent injury to Mr. Garza.

Considerations and basis for opinions

Officer Baker was patrolling in the area when he noticed a closed automotive repair business at 12:38 AM, with three men inside and outside a dusty looking Honda Accord with no license plates. The door was open and one man was inside while two were outside of the car. Officer Baker knew that Hondas were stolen often in Salem and he believed no one should be at the closed business at that time of night[4].

Officer Baker exited his patrol car and said hi to the men and asked them what was going on. Rather than receive some type of reasonable explanation he was met with Mr. Garza immediately approaching him and telling him that he did not need to be there and to leave. Officer Baker described Mr. Garza's demeanor as "very confrontational"[5]. It is a common tactic with individuals involved in criminal activity and confronted by the police to lie and/or attempt to bluff, intimidate and manipulate officers to distract or deter them from the suspect's activities. A trained, reasonable and prudent officer would be concerned by the reaction from Mr. Garza and would understand the necessity for further inquiry to establish what the explanation was for the circumstances.

At some point Mr. Garza said "I work here" and that Officer Baker was trespassing and needed to leave. Officer Baker simply asked for some verification that Mr. Garza worked there and Mr. Garza escalated again by cursing and raising his voice. Officer Baker commented that it looked like they might be stealing a car[6]. At no time did the other two men present say anything to verify Mr. Garza's claim or to deny any criminal conduct.

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[1] Officer Baker Police Report
[2] Ibid and Surveillance Video
[3] Surveillance Video
[4] Officer Baker Police Report and Deposition
[5] Ibid
[6] Ibid

Due to all of these factors a reasonable officer would believe he had reasonable suspicion that a potential crime may be occurring or about to occur including Criminal Trespass, Unauthorized Entry into a Motor Vehicle and Unauthorized Use of a Motor Vehicle. In fact, Officer Baker stated he believed he had reasonable suspicion at the time of the detention and use of force.

Mr. Garza also presented an officer safety concern due to his escalation of the encounter. A significant factor that the United States Supreme Court recognized and commented on in Graham v Connor (the foundational police use of force case) was that officers are often dealing with rapidly evolving circumstances requiring split second decision making and any review of their use of force must take this into consideration. In the surveillance video from the time that Officer Baker exits his patrol vehicle and stands on the ground until Mr. Garza is seen coming onto the screen walking toward Officer Baker is seven seconds. Eight seconds later Mr. Garza is seen raising his hand toward Officer Baker with his palm toward him in a defiant, dismissive, palm forward gesture then turning his back on Officer Baker and walking away[7].

These actions would be a "red flag" to an experienced and trained officer that the person has an uncooperative mindset and frequently may escalate to escaping or assaultive behavior. Mr. Garza walked toward the vehicle which posed enhanced safety risks to Officer Baker as he had no idea what items Mr. Garza had available to him within the car which could include improvised weapons or actual weapons. With the totality of circumstances presented and the very quick escalation by Mr. Garza a reasonable officer would recognize the need to control Mr. Garza's actions to prevent an escape or potential assault. Additionally, Officer Baker still had two other men present which although not displaying any problematic behavior at the time, could potentially change at any moment.

12 seconds after Mr. Garza is seen walking away from Officer Baker he is seen walking quickly back on screen being chased by Officer Baker who is able to grab his right arm and is clearly trying to control Mr. Garza. At one point Mr. Garza can be seen twisting his upper body to the right and looking back toward Officer Baker it what appears to be an effort to break away from Officer Baker's hold. There is an apparent struggle where Mr. Garza's left arm is not behind his back and Officer Baker is obviously attempting to get control of it in order to apply the handcuffs. Officer Baker's left hand moves toward Mr. Garza's upper back, head area in a pushing motion which seems to be consistent with attempting to keep Mr. Garza bent over in order to control him and get the handcuffs applied. After some noticeable effort, Officer Baker is able to get Mr. Garza handcuffed and sitting on the front bumper area of his patrol vehicle. He later escorted him to the right rear door of the patrol vehicle and placed him inside[8].

Clearly, due to the rapidly evolving events, Officer Baker had no time to try any other tactics, attempt to de-escalate, give any warnings prior to force, or utilize other

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[7] Surveillance Video
[8] Ibid

resources. From the time Mr. Garza turned away and walked toward the car to Officer Baker physically grabbing Mr. Garza was 13 seconds[9].

The surveillance video unfortunately appears to be taken from a distance and not of high clarity so it is difficult to observe the minute details of the encounter, however I believe what can be seen supports my observations noted above.

After Officer Baker was finally able to successfully detain Mr. Garza, he quickly investigated the circumstances with the aid of responding Officer's. After determining the car was not stolen and that Garza did live on the premises he immediately released Mr. Garza within twelve minutes of the original detention. At no time did he transport Mr. Garza anywhere nor did he issue him a criminal citation or take any other action consistent with an arrest. This detention and inquiry is consistent with what a reasonable and prudent officer would be trained to conduct pursuant to ORS 131.615 and took place within the vicinity of the stop and was limited to the immediate circumstances that aroused Officer Baker's suspicion. Furthermore it was very short in duration considering Officer Baker had to figure out Mr. Garza's identity to determine if he had a right to be on the property or not.

ORS 131.615 further provides in section (5) that "A peace officer making a stop may use the degree of force reasonably necessary to make the stop and ensure the safety of the peace officer, the person stopped or other persons who are present". Due to Mr. Garza's lack of cooperation with the stop followed by his choice to deliberately walk away from Officer Baker toward the car with unknown contents, then physically try and pull away from Officer Baker all contributed to Officer Baker's need to use force within the guidelines of ORS 131.615.

Conclusion

Although it turned out that Mr. Garza was a tenant at the location and apparently not involved in criminal activity at the time, he created circumstances that made it challenging at best, and dangerous at worst, for Officer Baker to determine this. Officer Baker's detention and force used on Mr. Garza was consistent with what a reasonable officer faced with similar circumstances would likely do. I also find it significant that the other two men present during the incident were cooperative and Officer Baker used no force against them.

Signature

9/22/2023

Date

[9] Ibid

ATTACHMENT A

Materials reviewed

Complaint
Answer To Complaint
Officer Baker Police Report
Salem Police Department Response Report (CAD)
Surveillance Video Footage
Radio Traffic Recording
David Baker Deposition Transcripts
Christopher Garza Deposition Transcripts
Hector Gonzales-Nunez Deposition Transcripts
Juan Gomez-Valles Deposition Transcripts
Kyle Felix Deposition Transcripts
Nathan Kizzar Deposition Transcripts
Yan Kuvaldin Deposition Transcripts
Computer File labeled "Discovery Provided by COS" containing multiple documents

ATTACHMENT B

Brian Harvey
Harvey Risk Mitigation and Training

Fee Schedule:

- Case review, study, preparation, consultation, depositions and testimony are billed at $300.00 per hour with a three hour minimum.
- Time spent in travel is billed at $75.00 per hour plus actual expenses, with the expenses being pre-paid or reimbursed by retaining counsel.
- Conducting site surveys, on scene or case investigations and interviews will be billed at $150.00 per hour plus actual expenses, with the expenses being pre-paid or reimbursed by retaining counsel.
- Non testimonial court time while under subpoena or request for attendance and on standby, will be billed at $150.00 per hour.

Rule 26 (B) Disclosures

I have provided consultation and testified in court as an expert witness in the following cases:

John Slaughter v. City of Tigard - US District Court, District of Oregon Trial

Estate of Richard Lee Shafer vs. City of Elgin, Oregon, Eric Kilpatrick and Kevin Lynch - U.S. District Court, District of Oregon Trial

State V. Woodford - Union County Oregon Circuit Court Trial

ATTACHMENT C

Brian Harvey
541-519-9379
SUMMARY OF QUALIFICATIONS

EDUCATION

Associate of Applied Science in Law Enforcement Apprenticeship, Lane Community College Eugene, OR
Graduate, Force Science Institute Certification Course
Graduate, Oregon Executive Leadership Development Institute
Graduate, Ford Foundation Community Leadership Course
Graduate, Idaho POST Reserve Academy
Graduate, Idaho POST Academy
Graduate, Central Oregon Reserve Academy
Graduate, Oregon DPSST Career Officer Development Course
DPSST Supervision Course
DPSST Middle Management Course
3,000+ hours DPSST certified training including extensive Survival Skills and Use of Force instructor related training
20+ years martial arts training

LAW ENFORCEMENT/PROFESSIONAL EXPERIENCE

Emmett Police Department, Emmett Idaho
1985-1986, **Patrol Officer**

Prineville Police Department
1987-1990, **Patrol Officer**

Springfield Police Department
1990-2002, **Police Officer**
SWAT team member
Field Training Officer
Detective
Lead Field Training Officer
Lead Defensive Tactics/Use of Force Instructor
Firearms Instructor
AIC Watch Commander (fill in on as needed basis)
First responder and investigator, Thurston High School mass shooting (1998)

Lane Community College
1996 -1997, **Instructor** -Use of Force and Defensive Tactics

Oregon Department of Public Safety Standards and Training (DPSST)
Statewide multi discipline training academy
1996-2002, **Part Time Instructor** – Defensive Tactics, Building Search, and Vehicle Stops
2002-2004, **Lieutenant** – provided oversight and coordination to basic police classes and career officer development classes. Teach a variety of classes.
2004-2006, **Captain** – Supervise Survival Skills Section – Defensive Tactics, Use of Force, Firearms, Health and Fitness, EVOC, Building Search, Vehicle Stops (EVOC, Building Search and Vehicle Stops were later moved to a newly created section)
2006 to 2017, Part Time Instructor -Use of Force

Baker City Police Department
2006-2009, **Lieutenant** 2nd in command of municipal police department. Manage daily operations and tactical incident command. Oversee, teach and review all department use of force and defensive tactics.

La Grande Police Department
2009 to 2020 (retired), **Chief of Police**. Chief Executive Officer of full service municipal police department and countywide 911 dispatch center. Incident Commander on major incidents and oversee all department use of force training and incident review.

Baker County Sheriff's Office
2020 to present, **Resident Deputy**. Provide full law enforcement and patrol services in the remote "panhandle" region of Baker County.

HISTORICAL INSTRUCTOR CERTIFICATIONS

DPSST:
Use of Force
Defensive Tactics
Confrontational Simulations
MILO/Range 3000 (Use of Force computer simulator)
Firearms
Building Search
Vehicle Stops
Criminal Law
Report Writing

Note: DPSST has changed titles and status of instructor certifications and combined certification topics together through the years.

PRESENTATIONS

Use of Force briefing - Oregon District Attorney's Association 35th annual conference
2004 Police Use of Force presentation/testimony Oregon House Judiciary Sub Committee
2004 Member Oregon Attorney Generals Task Force on Police Use of Deadly Force
2009 Featured co-presenter DPSST annual statewide Chief/Sheriff joint training on use of force
2010 Featured co-presenter Oregon Peace Officers Association Annual Conference, use of force

TRAINING AND OPERATIONS BACKROUND

I have provided training in survival skills topics for over 25 years for in excess of 1,000 law enforcement officers from a multitude of agencies throughout the state of Oregon. I supervised the Survival Skills Section at the Oregon Department of Public Safety Standards and Training (DPSST), Oregon's statewide training academy, and was responsible for all DPSST statewide regional Use of Force and Defensive Tactics training and all academy Use of Force, Defensive Tactics, Confrontational Simulation, Firearms, Building Search, Vehicle Stops, Health and Fitness and Emergency Vehicle Operations training. I also supervised the section during the construction and transition to a new state of the art academy facility. I co-supervised the development and implementation of a new and expanded 16-week academy curriculum. I co-authored the first ever fully comprehensive use of force curriculum for regional delivery and designed and provided use of force instructor training.

I have designed and implemented training through every stage including classroom, physical skills, reality based simulation, and actual field experience. I have been involved in every facet of police use of force including training of entry level officers, directly providing field training for numerous officers and coaching them through real world use of force incidents to supervising and managing all aspects of use of force at every level. I have been a use of force and defensive tactics instructor since 1995 and have personally been involved in hundreds of use of force incidents. I have also investigated officer's use of force, managed internal affairs investigations and implemented discipline up to and including terminations.

I have both formally and informally reviewed, or been consulted on, use of force incidents, training issues, personnel issues, major incidents, investigations, policies and practices for numerous law enforcement agencies throughout the state along with private sector entities.